FIRST NOTICE OF CLAIM

Provident - Main Office: PO Box 11588 - 272 Alpha Drive
Pittsburgh, PA 15238-0588
Toll-Free: 800.447.0360
Fax: 412.963.0148
claims@providentins.com
www.providentins.com
Business Hours: 8:30 a.m. to 5 p.m.

BOTH SECTIONS MUST BE COMPLETED

Name		Date of Birth / /	Social Security Number
Address	City	State Zip Code	Home Phone Number ( )
Email Address			Cell Phone Number ( )
What is your regular, full time occupation?		Employed By (Name of Company)	
Employer's Address	City	State Zip Code	Employer's Phone Number ( )
Please enclose pre-injury pay stub or the prior years W2 or Schedule C (if self-employed).	Wages/Earnings Hourly: Weekly:		Date of Hire (Full Time Occupation) / /
Time of Accident ☐ AM ☐ PM	Date of Accident / /	Place of Accident	Date Last Worked / /
What is your injury or illness?	How did it happen?		
Name and Address of Treating Physician		Name and Address of Hospital	
Did you lose any Time from Work? ☐ Yes ☐ No ☐ Unknown at this time		Did you file with Workers' Compensation? ☐ Yes ☐ No	
I was totally disabled from / / to / /			
I was partially disabled from / / to / /			
Date you have or are expected to return to work / /			

I CERTIFY THAT THE ABOVE ANSWERS ARE TRUE AND COMPLETE ACCORDING TO THE BEST OF MY KNOWLEDGE AND BELIEF. I hereby authorize any physician, hospital, insurer, governmental agency, other organization or person having any records, data or other information concerning me to furnish such records, data or information as may be requested by Provident or its duly authorized representative. I understand that in executing this authorization I waive the right for such information to be privileged. A copy of this authorization shall be considered as effective and valid as the original.

Date ______________________________ Claimant Signature ______________________________________

THE AUTHORIZATION ON THE REVERSE SIDE OF THIS FORM MUST BE SIGNED AND RETURNED TO PROVIDENT AGENCY.

THIS SECTION TO BE COMPLETED BY AUTHORIZED MEMBER OF FIRE DEPARTMENT, RESCUE OR AMBULANCE SQUAD

To be complete by an official of the Named Insured (must be someone other than the claimant or claimant's family member).

☐ Yes ☐ No – Claimant was a member of your organization at the time of injury or illness ☐ Yes ☐ No – Claimant was engaged in an authorized activity at the time of injury or illness			Policy Number
Name of Fire/Rescue/Ambulance Company/District or Relief Association		Your Municipality	
Print Name and Title	Signed		Date / /
Address City State	Zip Code	Telephone Number ( )	
Is the claimant a ☐ Volunteer ☐ Career ☐ PT employee ☐ Auxiliary ☐ Other			

See Fraud Warning Important Notice sheet attached.
Failure to complete this form in its entirety may result in a delay of processing your claim.